Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State North Carolina

SECTION 1 SINGLE STATE AGENCY ORGANIZATION

Citation
42 CFR 431.10
AT-79-29

1.1 Designation and Authority

(a) The Department of Health and Human Services is the single State agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named in this paragraph.)

ATTACHMENT 1.1-A is a certification signed by the State Attorney General identifying the single State agency and citing the legal authority under which it administers or supervises administration of the program.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State North Carolina

Citation
Sec. 1902(a)
of the Act

1.1(b) The State agency that administered or supervised the administration of the plan approved under title X of the **Act as of January 1, 1965, has been separately designated to administer or supervise the administration of that part of this plan which relates to blind individuals.**

___ Yes. The State agency so designated is

_____

_____.

This agency has a separate plan covering that portion of the State plan under title XIX for which it is responsible.

X Not applicable. The entire plan **under title XIX is administered or supervised by the State agency named in paragraph 1.1(a).**

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State North Carolina

Citation
Intergovernmental Cooperation Act of 1968

1.1 (c) Waivers of the single State agency requirement which are currently operative have been granted under authority of the Intergovernmental Cooperation Act of 1968.

__ Yes. ATTACHMENT 1.1-B describes these waivers and the approved alternative organizational arrangements.

X Not applicable. Waivers are no longer in effect.

__ Not applicable. No waivers have ever been granted.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State North Carolina

Citation			
42 CFR 431.10 AT-79-29	1.1(d)	___	The agency named in paragraph 1.1(a) has responsibility for all determinations of eligibility for Medicaid under this plan.
		x	Determinations of eligibility for Medicaid under this plan are made by the agency(ies) specified in ATTACHMENT 2.2-A. There is a written agreement between the agency named in paragraph 1.1(a) and other agency(ies) making such determinations for specific groups covered under this plan. The agreement defines the relationships and respective responsibilities of the agencies

Revision: HCFA-AT-80-38 (BPP)
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Citation		
42 CFR 431.10 AT-79-29	1.1(e)	All other provisions of this plan are administered by the Medicaid agency except for those functions for which **final authority has been granted to a Professional Standards Review Organization under title XI of the Act.**
	(f)	All other requirements of 42 CFR 431.10 are met.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State North Carolina

Citation
42 CFR 431.11
AT-79-29

1.2 Organization for Administration

(a) ATTACHMENT 1.2-A contains a description of the organization and functions of the Medicaid agency and an organization chart of the agency.

(b) Within the State agency, the _____ Division of Medical Assistance has been designated as the medical assistance unit. ATTACHMENT 1.2-B contains a description of the organization and functions of the medical assistance unit and an organization chart of the unit.

(c) ATTACHMENT 1.2-C contains a description of the kinds and numbers of professional medical personnel and supporting staff used in the administration of the plan and their responsibilities.

(d) Eligibility determinations are made by State or local staff of an agency other than the agency named in paragraph 1.1(a). ATTACHMENT 1.2-D contains a description of the staff designated to make such determinations and the functions they will perform.

X Not applicable. Only staff of the agency named in paragraph 1.1(a) make such determinations.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State North Carolina

Citation
42 CFR
431.50(b)
AT-79-29

1.3 Statewide Operation

The plan is in operation on a Statewide basis in accordance with all requirements of 42 CFR 431.50.

___ The plan is State administered.

X The plan is administered by the political subdivisions of the State and is mandatory on them.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State North Carolina

Citation		
42 CFR 431.12(b) AT-78-90	1.4	State Medical Care Advisory Committee There is an advisory committee to the Medicaid agency director on health and medical care services established in accordance with and meeting all the requirements of 42 CFR 431.12.
42 CFR 438.104	_X_	The State enrolls recipients in MCO, PIHP, PAHP, and/or PCCM programs. The State assures that it complies with 42 CFR 438.104(c) to consult with the Medical Care Advisory Committee in the review of marketing materials.

Revision: HCFA-PM-94-3 (MB)
APRIL 1994
State/Territory: NORTH CAROLINA

Citation

1.5 Pediatric Immunization Program

1928 of the Act

1. The State has implemented a program for the distribution of pediatric vaccines to program- registered providers for the immunization of federally vaccine-eligible children in accordance with section 1928 as indicated below.

   a. The State program will provide each vaccine-eligible child with medically appropriate vaccines according to the schedule developed by the Advisory Committee on Immunization Practices and without charge for the vaccines.

   b. The State will outreach and encourage a variety of providers to participate in the program and to administer vaccines in multiple settings, e.g., private health care providers, providers that receive funds under Title V of the Indian Health Care Improvement Act, health programs or facilities operated by Indian tribes, and maintain a list of program-registered providers.

   c. With respect to any population of vaccine-eligible children a substantial portion of whose parents have limited ability to speak the English language, the State will identify program-registered providers who are able to communicate with this vaccine-eligible population in the language and cultural context which is most appropriate.

   d. The State will instruct program-registered providers to determine eligibility in accordance with section 1928(b) and (h) of the Social Security Act.

   e. The State will assure that no program-registered provider will charge more for the administration of the vaccine than the regional maximum established by the Secretary. The State will inform program-registered providers of the maximum fee for the administration of vaccines.

   f. The State will assure that no vaccine-eligible child is denied vaccines because of an inability to pay an administration fee.

   g. Except as authorized under section 1915(b) of the Social Security Act or as permitted by the Secretary to prevent fraud or abuse, the State will not impose any additional qualifications or conditions, in addition to those indicated above, in order for a provider to qualify as a program-registered provider.

Revision: HCFA-PM-94-3 (MB)
APRIL 1994
State/Territory: NORTH CAROLINA

Citation

1928 of the Act

2. The State has not modified or repealed any Immunization Law in effect as of May 1, 1993 to reduce the amount of health insurance coverage of pediatric vaccines.

3. The State Medicaid Agency has coordinated with the State Public Health Agency in the completion of this preprint page.

4. The State agency with overall responsibility for the implementation and enforcement of the provisions of section 1928 is:

___ State Medicaid Agency

x State Public Health Agency

Citation:
1932 of the
Social Security Act

1.6 State Option to Use Managed Care

I. CITATION: SECTION 1932 (A)(1)(A) OF THE SOCIAL SECURITY ACT

The State of North Carolina proposes to enroll Medicaid beneficiaries on a mandatory basis into managed care entities (i.e. MCOs and PCCMs) in the absence of section 1115 or section 1915 (b) waiver authority. This authority is granted under section 1932 (a)(1)(A) of the Social Security Act (the Act). Under this authority, a State can amend its Medicaid State plan to require Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may *not* be used for PIHP or PAHP programs.

II. GENERAL DESCRIPTION OF THE PROGRAM AND PUBLIC PROCESS

1. Describe the types of entities with which the State will contract, and indicate whether the contract is a comprehensive risk contract. Include the payment method to be utilized (i.e. fee for service or capitation).

2. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the State will use to ensure ongoing public involvement once the state plan has been implemented.

   Carolina ACCESS (CA), implemented in 1991, is the Division of Medical Assistance (DMA) primary care case management (PCCM) program in which the primary care provider (PCP) coordinates patient care and acts as a gatekeeper. Providers are reimbursed fee for service and the PCPs receive a management fee for each recipient. The PCPs receive a management fee of
   $ 1.00 per member per month.

   ACCESS II, launched in July of 1998, is an enhanced primary care case management program in which Carolina ACCESS PCPs have joined together to form distinct networks headed by an administrative entity. The networks have developed care management and disease management strategies targeted to their respective populations. The PCPs receive a management fee of $ 2.50 per

Citation:
1932 of the
Social Security Act

1.6 State Option to Use Managed Care

member per month and all providers are paid on a fee-for-service basis. The administrative entity receives an additional management fee of $ 2.50 per member per month for the enhanced services.

Carolina ACCESS is the largest of the three programs and is viewed as the cornerstone of Medicaid managed care. ACCESS II is an enhancement of the Carolina ACCESS PCCM model. As of October 1, 2001, ACCESS II was operational in Mecklenburg County.

Health Care Connection, which began operating in June of 1996, is the State's HMO program in Mecklenburg County. Recipients have the choice of enrolling in the one participating Managed Care Organization (MCO), Carolina ACCESS, ACCESS II or with a Federally Qualified Health Center (FQHC).

A DMA Managed Care Section staff member regularly attends the North Carolina Commission on Children with Special Health Care Needs meetings that are held bi-monthly. This is a Governor-appointed group that was established as part of the Health Choice (CHIP) legislation in 1997.

The Governor's Commission on Children with Special Health Care Needs (CSHCNs) is the appropriate avenue for addressing care coordination issues amongst systems of care in North Carolina. The Commission members consist of a primary and a tertiary care provider in private and public practices, parents of a child with special needs, a local Health Department Director, a Special Education expert, a psychologist and a psychiatrist. In addition to the Commission Members, regular attendees include Division of Public Health (DPH) staff supporting the Commission, DPH Therapy Services staff, Assistive and Augmentative Devices staff, Division of Medical Assistance Managed Care staff, DMA/DPH Health Choice (SCHIP) staff, Early Intervention staff, State Health Plan Blue Cross/Blue Shield staff (administrators of the Health Choice (SCHIP program in NC) and Value Options staff, whom are involved in prior authorization activities for behavioral health services.

Citation:
1932 of the
Social Security Act

1.6 State Option to Use Managed Care

Members of this group present information regarding the activities of these agencies and discussed issues regarding care coordination and any other issue involving CSHCNs.

The State distributes Health Plan Employer Data and Information Set (HEDIS), [a set of standardized performance measures designed to reliably compare the performance of managed health care plans] data to Governor's Commission on Children with Special Health Care Needs as a means to identify issues that the Commission may need to address.

Attendance at the Commission's meetings is beneficial to DMA's Managed Care staff. The insight and guidance provided by the Commission members helps DMA in developing proposals. DMA plans to continue its attendance at the Commission meetings to maintain the access to input provided by stakeholder and consumers that this committee provides.

Recipients enrolled with the PCCM managed care option have public input through the Division's toll free hotline number that is manned from eight to five, Monday through Friday by Managed Care staff. Voice mail is available after hours for the recipient; the appropriate managed care staff person will return their call as soon as possible.

PCCM enrolled recipients also have public input through the Recipient Complaint Process. It is a mechanism to ensure providers are meeting contractual obligations and enrollees have access to appropriate and timely care. An internal complaint policy has been developed to ensure timely and consistent processing of complaints. The complaint process is described below:

If an enrollee has a complaint against the provider, the enrollee may seek resolution by submitting a completed and signed Carolina ACCESS Complaint form to the address indicated on the form. A copy of the form is available on website or from the county DSS. If the enrollee requires assistance with the Compliant Form, they may contact their caseworker at the county DSS office or call the Managed Care toll free number.

Citation: 1.6 State Option to Use Managed Care
1932 of the
Social Security Act

Complaints usually fall into one of the following five categories:
1. contract violations/program policy
2. professional conduct – general
3. professional conduct – physical, sexual or substance abuse
4. quality of care
5. program fraud/abuse

Enrollees who complete and sign the complaint form will receive a letter acknowledging receipt from the Quality Management Unit within 7 days of receipt. Upon receipt of a complaint, it is routed to the appropriate Managed Care staff person for action and resolution. Enrollees will not be notified of the outcome of the complaint due to confidentiality policies.

III. ASSURANCES AND COMPLIANCE WITH THE STATUTE AND REGULATIONS

The State plan program meets all the applicable requirements of:

- Section 1903 (m) of the Act, for MCOs and MCO contracts.
- Section 1905 (t) of the Act for PCCMs and PCCM contracts.
- Section 1932 (including Section (a)(1)(A)) of the Act, for the State's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities.
- 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in Section 1905 (a)(4)(C)
- 42 CFR 438 for MCOs and PCCMs.
- 42 CFR 434.6 of the general requirements for contracts.

Citation: 1.6 State Option to Use Managed Care
1932 of the
Social Security Act

- 42 CFR 438.6 (c) of the regulations for payments under any risk contracts.
- 42 CFR 447.362 for payments under any nonrisk contracts.
- 45 CFR part 74 for procurement of contracts.

IV. ELIGIBLE GROUPS

A. list all eligible groups that will be enrolled on a mandatory basis

With the exception of the populations listed in IV.B, recipients in the following aid categories will be required to enroll in one of the managed care programs described above:

- Work First for Family Assistance (formerly AFDC)
- Family and Children's Medicaid without Medicaid deductibles (formerly AFDC-related)
- Medicaid for the Blind and Disabled (MAB, MAD, MSB)
- Residents of Adult Care Homes (SAD)
- Qualified Alien

Children under age 19 identified as Children with Special Health Care Needs, dual eligibles, and Indians who are members of a Federally recognized tribes are exempt from mandatory enrollment.

Citation:
1932 of the
Social Security Act

1.6 State Option to Use Managed Care

B. Mandatory exempt groups

1. Recipients who are eligible for Medicare

__X__ The State will allow these individuals to voluntarily enroll in the managed care program.

Dual Eligibles will be allowed to voluntarily enroll in Carolina ACCESS or ACCESS II. Dual Eligibles are not allowed to enroll in the Mecklenburg County MCO.

2. Indians who are members of Federally recognized tribes except when the MCO or PCCM is the Indian Health Service; or an Indian Health program or Urban Indian program operated by a tribe or tribal organization under a contract, grant, cooperative agreement or compact with the Indian Health Service.

__X__ The State will allow these individuals to voluntarily enroll in the managed care program.

3. Children under the age of 19 years, who are eligible for Supplemental Security Income under Title XVI.

__X__ The State will allow these individuals to voluntarily enroll in the managed care program.

4. Children under the age of 19 years who are eligible under section 1902(e)(3) of the Act.

____ The State will allow these individuals to voluntarily enroll in the managed care program.

Citation:
1932 of the
Social Security Act

1.6 State Option to Use Managed Care

5. Children under the age of 19 years who are foster care or other out-of-the-home placement.

_X_ The State will allow these individuals to voluntarily enroll in the managed care program.

6. Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E

_X_ The State will allow these individuals to voluntarily enroll in the managed care program.

Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of Title V, and is defined by the state in terms of either program participation or special health care needs.

_X_ The State will allow these individuals to voluntarily enroll in the managed care program.

c. list all other groups that ARE PERMITTED TO ENROLL on a voluntary basis

Community Alternative Program (CAP) Enrollees are allowed to enroll in Carolina ACCESS and ACCESS II.

1. Is the State's definition of these children in terms of program participation or special health care needs?

The State defines these children in terms of special health care needs and program participation in Development Evaluation Center (DEC) and Child Special Health Services (CSHS).

Citation:
1932 of the
Social Security Act

1.6 State Option to Use Managed Care

2. Does the scope of these Title V services include services received through a family-centered, community-based, coordinated care system?
   Title V program participants are identified as those receiving DEC services and CSHS.

3. How does the State identify the following groups of children who are exempt from mandatory enrollment:

   a. Children under 19 years of age who are eligible for SSI under Title XVI;

      The State identifies this group by Medicaid eligibility category of assistance.

   b. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act;

      The State does not enroll this population in the managed care programs.

   c. Children under 19 years of age who are receiving foster care or adoption assistance under title IV-E of the Act.

      The State identifies this group by the Medicaid eligibility category of assistance.

4. What is the State's process for allowing children to request an exemption based on the special needs criteria as defined in the State Plan if they are not initially identified as exempt from mandatory enrollment?

   Enrollment in a managed care program health care option is voluntary for Children with Special Health Care Needs (CSHCN).

Citation:
1932 of the
Social Security Act

1.6 State Option to Use Managed Care

In addition to the categories listed above, the Division of Medical Assistance has instituted a questionnaire, with 5 2-part questions, for self-identification of children with Special Health Care Needs at the time of enrollment in Medicaid or Health Choice (SCHIP). This information is captured in the Eligibility Information System (EIS) to assist with reporting and monitoring of CSHCN.

The State has an internal exemption process that approves or denies Medicaid recipients' exemption requests from participation in our PCCM option for medical reasons. The medical exemption requests are reviewed and approved by the Quality Management unit. Recipient who have ESRD, terminal illness or require hospice services are automatically made exempt by the State.

An exemption is deemed necessary when it is determined that in order to maintain continuity of care it would be necessary to medically exempt the recipient from the PCCM health care option. The recipient and the county DSS office are notified in writing of the approval or denial of an exemption request.

Recipients may request a disenrollment from the MCO at any time for any reason. The State's contract with the MCO clearly states the recipient's right to voluntarily disenroll at any time without cause.

5. How does the State identify the following groups who are exempt from mandatory enrollment into managed care:

   a. Individuals who are also eligible for Medicare.

   These recipients are identified by Medicaid eligibility category of assistance.

Citation: 1.6 State Option to Use Managed Care
1932 of the

Social Security Act

b. There is no eligibility category group designated for the Native American population; they are eligible for Medicaid under existing program aid categories. When a Native American applies for Medicaid, he is automatically exempted from enrollment into managed care based on his membership in a federally recognized tribe and not on his eligibility group.

E. List other populations (not previously mentioned) who are exempt from mandatory enrollment.

There are no other exempt populations (not previously mentioned).

V. ENROLLMENT PROCESS

a. definitions

An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through State records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient.

A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.

b. state process for enrollment by default

1. Describe how the state's default enrollment process will preserve:

   a. the existing provider-recipient relationship;
   b. the relationship with providers that have traditionally served Medicaid recipients;

Citation: 1.6 State Option to Use Managed Care
1932 of the

Social Security Act

c. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702 (a)(4)), disenrollment for cause in accordance with 42 CFR 438.56(d)(2). and;
d. The division strives to minimize the use of auto-assignments.

The caseworkers in each local county Department of Social Services (DSS) are responsible for auto-assigning in all counties excluding Mecklenburg County. An enrollment broker, Public Consulting Group (PCG), handles auto assignments in Mecklenburg County.

The State assures that default enrollment will be based first upon maintaining existing provider-patient relationships. Most beneficiaries receive education as to their managed care options verbally through staff at their respective county DSS. Inquiries are made for potential default enrollment as to current provider-patient relationships when recipients do not select a primary care provider or HMO at the time of the visit. Some beneficiaries, particularly Supplemental Security Income (SSI) recipients, do not visit the social services office for Medicaid application and/or reapplication. In these cases, written materials describing the managed care options are mailed to them along with a deadline for notification of PCP/MCO selection.

Attempts are made to contact beneficiaries by telephone or letter if they do not respond within the time frame; inquiries are made about existing relationships with providers when contact is made.

If it is not possible to obtain provider-patient history, beneficiaries are assigned to providers based upon equitable distribution among participating Managed Care Entities (MCEs), including PCPs and the MCO (Mecklenburg County only) as available in the recipient's county of residence.

Citation:
1932 of the
Social Security Act

1.6 State Option to Use Managed Care

Caseworkers are told to look at the provider restrictions, e.g. patients 21 and under or established patients only, listed in the State Eligibility Information System (EIS), and geographical proximity to the provider before auto assigning a recipient.

2. As part of the state's discussion on the default enrollment process, include the following items:
   a. the time frame for recipients to choose a health plan before being auto-assigned;
   b. the State's process for notifying Medicaid recipients of their auto-assignment;
   c. the State's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment if the default assignment process is problematic for the beneficiary.
   d. a description of the default assignment algorithm used for auto-assignment
   e. how the State will monitor any changes in the rate of default assignment

   Recipients are notified of managed care programs when they apply for Medicaid or when they are due for their eligibility review. Because SSI recipients do not apply for Medicaid, they are listed on a report. When they become eligible for Medicaid, a letter is sent to them asking them to contact DSS to select a PCP. The report is monitored to determine if SSI recipients are getting enrolled.

   The county DSS or PCG staff reviews the SSI exempt report and auto-assign all recipients who have been on the report for 30 days or more and
   assigns them to a PCP. Counties then send a letter to the recipient informing them of their PCP along with a copy of the recipient handbook.

Citation: 1.6 State Option to Use Managed Care
1932 of the
Social Security Act

Recipients in Mecklenburg County are assigned to a provider by using an algorithm that includes paid claims information on each recipient. Data on recipients who are eligible for automatic assignment is run to determine if the recipient has any PCP paid claims. If the data on a recipient show more than one PCP with a paid claim, the PCP with the highest frequency of visits is determined to be the PCP of choice. The PCP of choice is subsequently compared to the provider directory file for a match, and then it is determined if the MCO or PCCM has the PCP in their networks.

Paid claims history is searched to determine if the recipient had any visits to specialists. If the recipient's data show more than one specialist with paid claims, the specialist with the highest frequency of visits is selected as the specialist of choice.

Paid claims history is searched to determine if the recipient had any hospital visits. If there is a hospital claim and if the MCO or PCCM has the hospital in their network, it is allowed to remain as a possible assignment.

If no claims were paid to PCPs or specialists, and only hospital claims existed, then the MCO or PCCM with that hospital in their network, is allowed to remain as possible assignment.

If no paid claims history exists, the recipient is assigned according to the algorithm assignment used for the general population.

c. state assurances on the enrollment process

1. The State Plan program assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.

Citation:
1932 of the
Social Security Act

1.6 State Option to Use Managed Care

2. The State Plan program assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 412.62 (f)(1)(ii).

   _X_ The State Plan program applies the rural exception to choice requirements of 42 CFR 438.52 (a) for MCOs and PCCMs. (Place check mark to indicate state's affirmation.)

3. The State plan program will only limit enrollment into a single HIO, if and only if the HIO is one of the entities described in section 1932 (a)(3) (C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)

d. disenrollment

1. The State Plan program assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56 (c).

   The State assures that beneficiaries will be permitted to disenroll from a managed care plan or change Carolina ACCESS/ACCESS II PCPs on a month to month basis. However, the recipient must select another managed care plan option for health care services, if the recipient is in one of the mandatory eligibility categories for enrollment. The county DSS is responsible for processing an enrollee's change request. Changes are effective the first day of the month following the change in the State eligibility system.

2. What are the additional circumstances of "cause" for disenrollment? (If any.)

VI. INFORMATION REQUIREMENTS FOR BENEFICIARIES

The State Plan program assures that its plan is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932 (a)(1)(A) state plan amendments.

Citation:
1932 of the
Social Security Act

1.6 State Option to Use Managed Care

The State assures that it will provide information to beneficiaries in an easily understood format on providers, enrollee rights and responsibilities, grievance and appeal procedures, covered items and services, and benefits not covered by the MCE. The State provides comparative information on benefits and cost sharing, service areas, and the special features of each MCE. The State assures CMS that it will also provide comparative information on quality and performance of participating managed care entities to the extent that this information is available. All information will be written in language at the fifth grade level of reading comprehension.

Marketing materials for PCCM potential enrollees are provided by the State. The State's risk contract with the MCO allows the MCO to develop marketing materials and engage in marketing activities in accordance with requirements stated in 42 C.F.R. 438.104.

VII. DESCRIPTION OF EXCLUDED SERVICES FOR EACH MODEL (MCO & PCCM)

The excluded services for the MCO model, referred to as Out-of-Plan Benefits, are listed below:

CAP Services
At-Risk Case Management
Child Service Coordination
Dental
D.S.S. Non-Emergency Transportation
Developmental Evaluation Center Services
HIV Case Management
ICF/MR
Maternity Care Coordination
Mental Health and Substance Abuse
Mental Health – Inpatient & Outpatient
Personal Care Services
Prescription Drugs
School-Related and Head Start Therapies

Skilled or Intermediate Nursing Care

Citation:
1932 of the
Social Security Act

1.6 State Option to Use Managed Care

The following Carolina ACCESS and ACCESS II exempt services do not require PCPs authorization:

Ambulance
Anesthesiology
At Risk Case Management
CAP Services
Certified Nurse Anesthetist
Child Care Coordination Services
Dental
Developmental Evaluation Centers
Diagnosis and treatment of emergency conditions
Eye exam for glasses
Family Planning
Head Start Programs
Health Department Services
Hearing Aids
Hospice
Laboratory Services
Maternity Care Coordination
Mental Health
Optical Supplies/Visual Aids
Pathology Services
Pharmacy
School Services
X-Ray Services not done in the Hospital

VIII. SANCTIONS

Describe how the program will implement Subpart I of 42 CFR 438 and monitor for violations that involve the actions and failures in this subpart to acts specific in this subpart (42 CFR 438.726 (a)).

Contractual noncompliance issues or access problems that are detected in the PCCM program as a result of recipient surveys or recipient complaints are addressed in a number of ways, depending on the nature and urgency of the problem. Generally, contact is made with the provider to evaluate the issue; depending on the outcome of the evaluation, a corrective action plan might be implemented and/or the provider might be sanctioned. An example of a sanction would be suspension of management fees or restricting the provider from taking on additional Carolina ACCESS patients.

The State monitors the MCO for violations through periodic reviews including onsite audits, recipient or other complaints, financial status or any other source. Intermediate sanctions may be imposed for the reasons and in the manner outlined in 42 C.F.R. 438.702 and 42 C.F.R. 438.704.

The State shall impose temporary management if it finds that the MCO has repeatedly failed to meet the substantive requirements in section 1903(m) or 1932 of the Social Security Act. The State will grant enrollees the right to disenroll without cause and will notify them of this right.

Revision: HCFA-PM-91- 4 (BPD) AUGUST 1991 OMB No.: 0938-

State: North Carolina

SECTION 2 - COVERAGE AND ELIGIBILITY

Citation
42 CFR
435.10 and
Subpart J

2.1 Application, Determination of Eligibility and Furnishing Medicaid

(a) The Medicaid agency meets all requirements of 42 CFR Part 435, Subpart J for processing applications, determining eligibility, and furnishing Medicaid.

Revision: HCFA-PM-93-2 (MB)
MARCH 1993

State: North Carolina

Citation				
42 CFR 435.914 of the Act	2.1 (b)(1)			Except as provided in items 2.1(b)(2) and (3) below, 1902(a)(34) individuals are entitled to Medicaid services under the plan during the three months preceding the month of application, if they were, or on application would have been, eligible. The effective date if prospective and retroactive eligibility is specified in ATTACHMENT 2.6-A.
1902(e)(8) and 1905(a) of the Act			(2)	For individuals who are eligible for Medicare cost-sharing expenses as qualified Medicare beneficiaries under Section 1902(a)(10)(E)(i) of the Act, coverage is available for services furnished after the end of the month in which the individual is first determined to be a qualified Medicare beneficiary. ATTACHMENT 2.6-A specifies the requirements for determination of eligibility for this group.
1902(a)(47) and 1920 of the Act		x	(3)	Pregnant women are entitled to ambulatory prenatal care under the plan during a presumptive eligibility period in accordance with section 1920 of the Act ATTACHMENT 2.6-A specifies the requirements for determination of eligibility for this group.

Revision: HCFA-PM-6 (MB) OMB No.
September 1991

State/Territory: North Carolina

Citation

1902(a)(55) of the Act	2.1(d) The Medicaid agency has procedures to take applications, assist applicants, and perform initial processing of applications from those low income pregnant ---------women, infants, and children under age 19, described in 1902(a) (10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a) (10) (A)(i)(VII), and (a) (10) (A)(ii)(IX) at locations other than those used by the title IV-A program including FQHCs and disproportionate share hospitals. Such application forms do not include the ADFC form except as permitted by HCFA instructions.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State: North Carolina

Citation
42 CFR
435.10

2.2 Coverage and Conditions of Eligibility

Medicaid is available to the groups specified in ATTACHMENT 2.2-A.

____ Mandatory categorically needy and other required special groups only.

____ Mandatory categorically needy, other required special groups, and the medically needy, but no other optional groups.

____ Mandatory categorically needy, other required special groups, and specified optional groups.

x Mandatory categorically needy, other required special groups, specified optional groups, and the medically needy.

The conditions of eligibility that must be met are specified in ATTACHMENT 2.6-A.

All applicable requirements of 42 CFR Part 435 and sections 1902(a)(10)(A)(i)(IV), (V), and (VI), 1902(a)(10)(A)(ii)(XI), 1902(a)(10)(E), 1902(l) and (m), 1905(p), (q) and (s), 1920, and 1925 of the Act are met.

Revision: HCFA-PM-87-4 (BERC) OMB No.: 0938-0193
MARCH 1987

State: North Carolina

Citation	2.3 Residence
435.10 and 435.403, and 1902(b) of the Act, P.L. 99-272 (Section 9529) and P.L. 99-509 (Section 9405)	Medicaid is furnished to eligible individuals who are residents of the State under 42 CFR 435.403,regardless of whether or not the individuals maintain the residence permanently or maintain it at a fixed address

Revision: HCFA-PM-87-4 (BERC) OMB No.: 0938-0193
MARCH 1987

State: North Carolina

Citation	2.4 Blindness
42 CFR 435.530(b) 42 CFR 435.531 AT-78-90 AT-79-29	All of the requirements of 42 CFR 435.530 and 42 CFR 435.531 are met. The more restrictive definition of blindness in terms of ophthalmic measurement used in this plan is specified in ATTACHMENT 2.2-A.

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

OMB No. 0938-

State: North Carolina

Citation	2.5	Disability
42 CFR 435.121, 435.540(b)		All of the requirements of 42 CFR 435.540 and 435.541 are met. The State uses the same definition of disability used under the SSI program unless a more restrictive definition of disability is specified in Item A.13.b. of ATTACHMENT 2.2-A of this plan. This includes the option set forth in 42 USC 1396(v) for making independent disability determinations subject to final administrative determinations on such applications by SSA by using the definition of disability in 20 CFR 416.901 et seq. of the Act as reflected in 42 CFR 435.541.

Revision: HCFA-PM-92-1 (MB)
FEBRUARY 1992

State: North Carolina

Citation(s)	2.6	Financial Eligibility
42 CFR 435.10 and Subparts G & H 1902(a)(10)(A)(i) (III), (IV), (V), (VI), and (VII), 1902(a)(10)(A)(ii) (IX), 1902(a)(10) (A)(ii)(x), 1902 (a)(10)(C), 1902(f), 1902(l) and (m), 1905(p) and (s), 1902(r)(2), and 1920	(a)	The financial eligibility conditions for Medicaid-only eligibility groups and for persons deemed to be cash assistance recipients are described in ATTACHMENT 2.6-A.

Revision: HCFA-PM-86-20 (BERC) OMB-No. 0938-0193
SEPTEMBER 1986

State/Territory: North Carolina

Citation	2.7	Medicaid Furnished out of State
431.52 and 1902(b) of the Act. P.L. 99-272 (Section 9529)		Medicaid is furnished under the conditions specified in 42 CFR 431.52 to an eligible individual who is a resident of the State while the individual is in another State, to the same extent that Medicaid is furnished to residents in the State.

Revision: HCFA-PM-91- 4 (BPD) OMB No: 0938-
AUGUST 1991

State/Territory: North Carolina

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation

3.1 Amount, Duration, and Scope of Services

42 CFR Part 440, Subpart B 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act

(a) Medicaid is provided in accordance with the requirements of 42 CFR Part 440, Subpart B and sections 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act.

1925 of the Act

(1) Categorically needy.

Services for the categorically needy are described below and in ATTACHMENT 3.1-A. These services include:

1902(a)(10)(A) and 1905(a) of the Act

(i) Each item or service listed in section 1905(a) (1) through (5) and (21) of the Act is provided as defined in 42 CFR Part 440,Subpart A, or, for EPSDT services, section 1905(r) and 42 CFR Part 441, Subpart B.

(ii) Nurse-midwife services listed in section 1905(a)(17) of the Act, as defined in 42 CFR 440.165 are provided to the extent that nurse-midwives are authorized to practice under State law or regulation. Nurse-midwives are permitted to enter into independent provider agreements with the Medicaid agency without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider.

__ Not applicable. Nurse-midwives are not authorized to practice in this State.

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: North Carolina

Citation			3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)
1902(e)(5) of the Act		(iii)	Pregnancy- related, including family planning services, and postpartum services for a 60-day period (beginning on the day pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.
	X	(iv)	Services for medical conditions that may complicate the pregnancy (other than pregnancy-related or postpartum services) are provided to pregnant women.
(F), 1902 (a) (10) (F) (VII)		(v)	Services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions that may complicate pregnancy are the same services provided to poverty level pregnant women eligible under the provision of sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act.

Revision: HCFA-PM-91- 4 (BPD) OMB No. 0938-
AUGUST 1991

State/Territory: North Carolina

Citation	3.1(a)(1)	Amount, Duration. and Scope-of-Services: Categorically Needy (Continued)
1902(a))(10)(D		(vi) Home health services are provided to individuals entitled to nursing facility services as indicated in item 3.1(b) of this plan.
1902(e)(7) of the Act		(vii) Inpatient services that are being furnished to infants and children described in section 1902(l)(1)(B) through (D), or section 1905(n)(2) of the Act on the date the infant or child attains the maximum age for coverage under the approved State plan will continue until the end of the stay for which the inpatient services are furnished.
1902(e)(9) of the Act		(viii) Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.
1902(a)(52) and 1925 of the Act		(ix) Services are provided to families eligible under section 1925 of the Act as indicated in item 3.5 of this plan.

ATTACHMENT-3.1-A identifies the medical and remedial services provided to the categorically needy, specifies all limitations on the amount, duration and scope of those services, and lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

State/Territory: North Carolina

Citation 3.1 Amount, Duration, and Scope of Services (continued)

42 CFR, Part 440 Subpart B (a)(2) Medically needy.

x This State plan covers the medically needy The services described below and in ATTACHMENT 3.1-B are provided.

Services for the medically needy include:

1902(a)(10)(C)(iv) of the Act
42 CFR 440.220 (i) If services in an institution for mental diseases (42 CFR 440.140 and 440.160) or an intermediate care facility for the mentally retarded (or both) are provided to any medically needy group, then each medically needy group is provided either the services listed in section 1905(a)(1) through (5) and (17) of the Act, or seven of the services listed in section 1905(a)(1)through (20). The services are provided as defined in 42 CFR Part 440, Subpart A and in sections 1902, 1905, and 1915 of the Act.

___ Not applicable with respect to nurse-midwife services under section 1902(a)(17). Nurse-midwives are not authorized to practice in this State.

1902(e)(5) of the Act (ii) Prenatal care and delivery services for pregnant women.

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: North Carolina

Citation 3.1(a)(2) Amount, Duration, and Scope of Services:
Medically Needy (Continued)

(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day the pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

(iv) Services for any other medical condition that may complicate the pregnancy (other than pregnancy related and postpartum services) are provided to pregnant women.

(v) Ambulatory services, as defined in ATTACHMENT 3.1-B, for recipients under age 18 and recipients entitled to institutional services

___ Not applicable with respect to recipients entitled to institutional services; the plan does not cover those services for the medically needy.

(vi) Home health services to recipients entitled to nursing facility services an indicated in item 3.1(b) of this plan.

42 CFR 440.140 440.150,440.160, 1902(a)(10)(c) Subpart B, 442.441, Subpart C 1902(a)(20) and (21) of the Act

x (vii) Services in an institution for mental diseases for individuals over age 65.

x (viii) Services in an intermediate care facility for the mentally retarded.

1902(a)(10)(D)

x (ix) Inpatient psychiatric services for individuals under age 21.

Revision: HCFA-PM-93-5 (MB)
MAY 1993

State: North Carolina

Citation

3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (Continued)

1902(e)(9) of Act	___ (x)	Respiratory care services are provided to ventilator dependent individuals as indicated in Item 3.1(h) of this plan.
1905(a)(23) and 1929 of the Act	___ (xi)	Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A and Appendices A-G to Supplement 2 to Attachment 3.1-A.

ATTACHMENT 3.1-B identifies the services provided to each covered group of the medically needy; specifies all limitations on the amount, duration, and scope of those items; and specifies the ambulatory services provided under this plan and any limitations on them. It also lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.